

(i) Obtain CMS's approval of the continuation area, the marketing materials that describe the option, and the M+C organization's assurances of access to services.

(ii) Describe the option(s) in the member materials it offers and make the option available to all enrollees residing in the continuation area.

(2) An enrollee who moves out of the service area into the geographic area designated as the continuation area has the choice of continuing enrollment or disenrolling from the plan. The enrollee must make the choice of continuing enrollment in a manner specified by CMS. If no choice is made, the enrollee must be disenrolled from the plan.

(d) *Specific requirements—*

(1) *Continuation of enrollment benefits.* The M+C organization must, at a minimum, provide or arrange for the Medicare-covered benefits as described in § 422.101(a).

(2) *Reasonable access.* The M+C organization must ensure reasonable access in the continuation area—

(i) Through contracts with providers, or through direct payment of claims that satisfy the requirements in § 422.100(b)(2), to other providers who meet the requirement in subpart E of this part; and

(ii) By ensuring that the access requirements of § 422.112 are met.

(3) *Reasonable cost-sharing.* For services furnished in the continuation area, an enrollee's cost-sharing liability is limited to the cost-sharing amounts required in the M+C plan's service area (in which the enrollee no longer resides).

(4) *Protection of enrollee rights.* An M+C organization that offers a continuation of enrollment option must convey all enrollee rights conferred under this rule, with the understanding that—

(i) The ultimate responsibility for all appeals and grievance requirements remain with the organization that is receiving payment from CMS; and

(ii) Organizations that require enrollees to give advance notice of intent to use the continuation of enrollment option, must stipulate the notification process in the marketing materials.

(e) *Capitation payments.* CMS's capitation payments to all M+C organizations, for all Medicare enrollees, are based on rates established on the basis of the enrollee's permanent residence, regardless of where he or she receives services.

[63 FR 35071, June 26, 1998; 63 FR 52611, Oct. 1, 1998, as amended at 65 FR 40316, June 29, 2000]

§ 422.56 Limitations on enrollment in an M+C MSA plan.

(a) *General.* An individual is not eligible to elect an M+C MSA plan—

(1) If the number of individuals enrolled in M+C MSA plans has reached 390,000;

(2) Unless the individual provides assurances that are satisfactory to CMS that he or she will reside in the United States for at least 183 days during the year for which the election is effective; or

(3) On or after January 1, 2003, unless the enrollment is the continuation of an enrollment in effect as of that date.

(b) *Individuals eligible for or covered under other health benefits program.* An individual who is enrolled in a Federal Employee Health Benefit plan under 5 U.S.C. chapter 89, or is eligible for health care benefits through the Veteran's Administration under 10 U.S.C. chapter 55 or the Department of Defense under 38 U.S.C. chapter 17, may not enroll in an M+C MSA plan.

(c) *Individuals eligible for Medicare cost-sharing under Medicaid State plans.* An individual who is entitled to coverage of Medicare cost-sharing under a State plan under title XIX of the Act is not eligible to enroll in an M+C MSA plan.

(d) *Other limitations.* An individual who receives health benefits that cover all or part of the annual deductible under the M+C MSA plan may not enroll in an M+C MSA plan. Examples of this type of coverage include, but are not limited to, primary health care coverage other than Medicare, current coverage under the Medicare hospice benefit, supplemental insurance policies not specifically permitted under § 422.104, and retirement health benefits.

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